ALLEVIATE LASER THERAPY

PATIENT INFORMATION SHEET

Name: _____ **Date:** _____ **Sex: M / F**

Full Address: _____

Home Phone #: _____ **Work Phone #:** _____

Employer: _____ **Dr's Name / Ph. #:** _____

Date of Birth: _____ **Health Card #:** _____

Current Health Habits	Yes	No	Patients Comments	Doctor's Comments
Did/do you smoke?				
Did/do you drink any alcohol?				
Are you concerned about your diet?				
Have you been in accidents?				
Current medications? How Long?				
Allergies?				
Exercise regularly?				
Females; Are you pregnant?				
Sleeping posture ☐ side ☐stomach ☐back				

Is there a family history of: Heart Disease ☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Other _____

Present Complaint: _____

Pain or problem started on _____
Pains are: Sharp ☐ Dull ☐ Constant ☐ Intermittent ☐
What activities aggravate your condition/pain? _____
What activities lessen your condition/pain? _____
Is condition worse during certain times of the day? _____
Is this condition interfering with your work? ____ Sleep? ____ Daily Routine? ____ Other? ____
Is condition getting progressively worse? _____
Have you seen any other Doctors seen for this condition? _____
Any effective treatments? _____
Have you experienced any side effects from the drugs and surgeries? _____

Other Symptoms:

☐	Headaches	☐	Pins and Needles in legs	☐	Fainting
☐	Neck Pain	☐	Pins and Needles in Arms	☐	Loss of Smell
☐	Sleeping Problems	☐	Numbness in Fingers	☐	Loss of Taste
☐	Back Pain	☐	Numbness in Toes	☐	Diarrhea
☐	Nervousness	☐	Shortness of Breath	☐	Feet Cold
☐	Tension	☐	Fatigue	☐	Hands Cold
☐	Irritability	☐	Depression	☐	Stomach Upset
☐	Chest Pains	☐	Lights Bothers Eyes	☐	Constipation
☐	Dizziness	☐	Loss of Memory	☐	Cold Sweats
☐	Face Flushed	☐	Ears Ring	☐	Loss of Balance
☐	Neck Stiff	☐	Fever	☐	Buzzing in Ears